

Maine PCMH Pilot – Phase 2 Expansion & MaineCare Health Homes Initiative

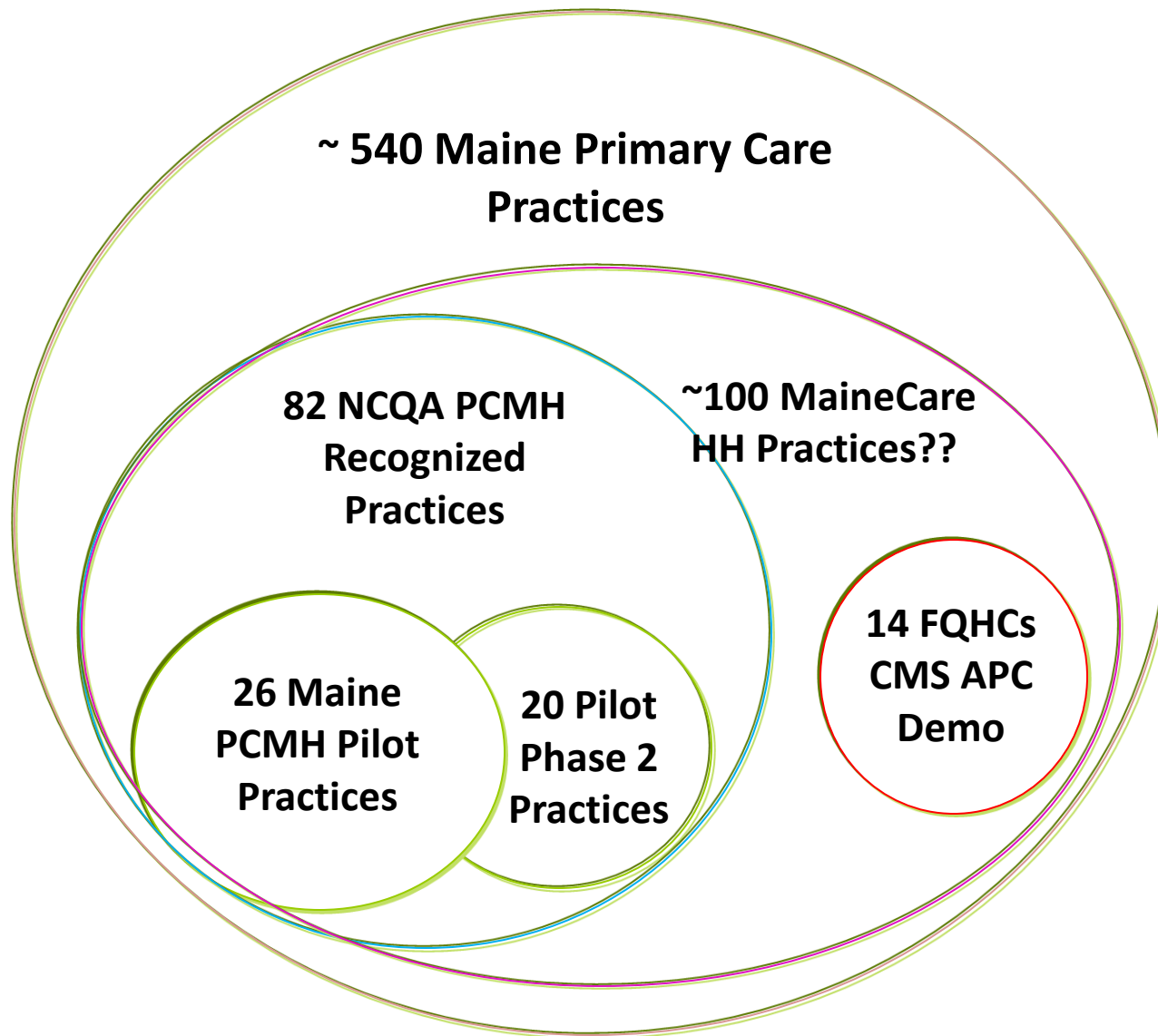
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February 2012



Maine's Medical Home Movement



Defining Medical Home Model

“A **medical home** is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

- American Academy Pediatrics (1964)





Maine PCMH Pilot

Key elements:

- Convened by MQF, Maine Quality Counts, MHMC
- Originally, 3-year multi-payer PCMH pilot (now 5 yrs)
- Collaborative effort of key stakeholders, major payers
- Adopted common mission & vision, guiding principles for Maine PCMH model
- Selected 22 adult / 4 pedi PCP practices across state
- Supporting practice transformation & shared learnings beyond pilot practices
- Committed to engaging consumers/ patients at all levels
- Conducting rigorous outcomes evaluation (clinical, cost, patient experience of care)

Maine PCMH Pilot Practices Ownership Types

Legend

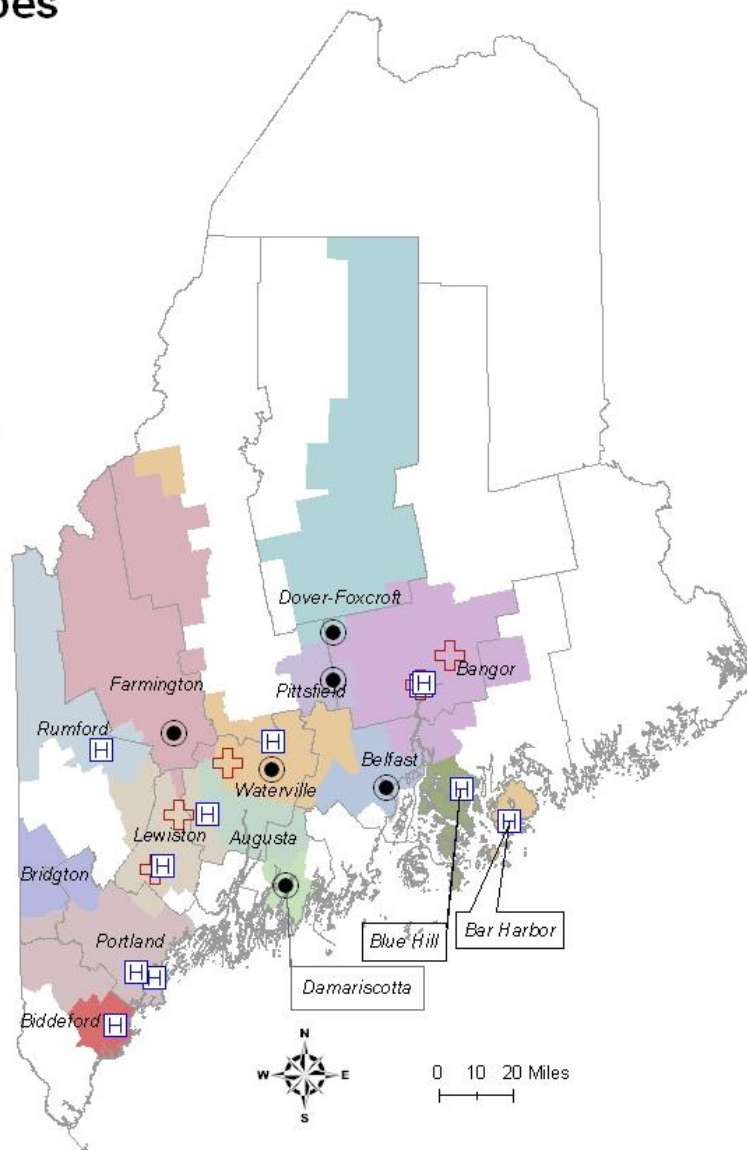
Ownership Type

-  FQHC
-  Private
-  H-O

— County lines

Hosp. Service Areas w. Pilot Practices

-  Augusta
-  Bangor
-  Bar Harbor
-  Belfast
-  Biddeford
-  Blue Hill
-  Bridgton
-  Damariscotta
-  Dover-Foxcroft
-  Farmington
-  Lewiston
-  Pittsfield
-  Portland
-  Rumford
-  Waterville





Maine PCMH Pilot Practice “Core Expectations”

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT



Maine PCMH Pilot Payment Model

- Major private payers participating: Anthem, Aetna, HPHC, Medicaid & Medicare (MAPCP)
- Using “standard” 3-component payment:
 - Prospective (pmpm) care management payment – approx \$3pmpm commercial & Medicaid; \$7 pmpm Medicare
 - Ongoing FFS payments
 - Performance payment for meeting quality targets (existing P4P programs)



Maine PCMH Pilot-MAPCP Timeline

Jan 2010

2011

2012

2013

2014

Jan 1, 2010

ME PCMH Pilot - Original

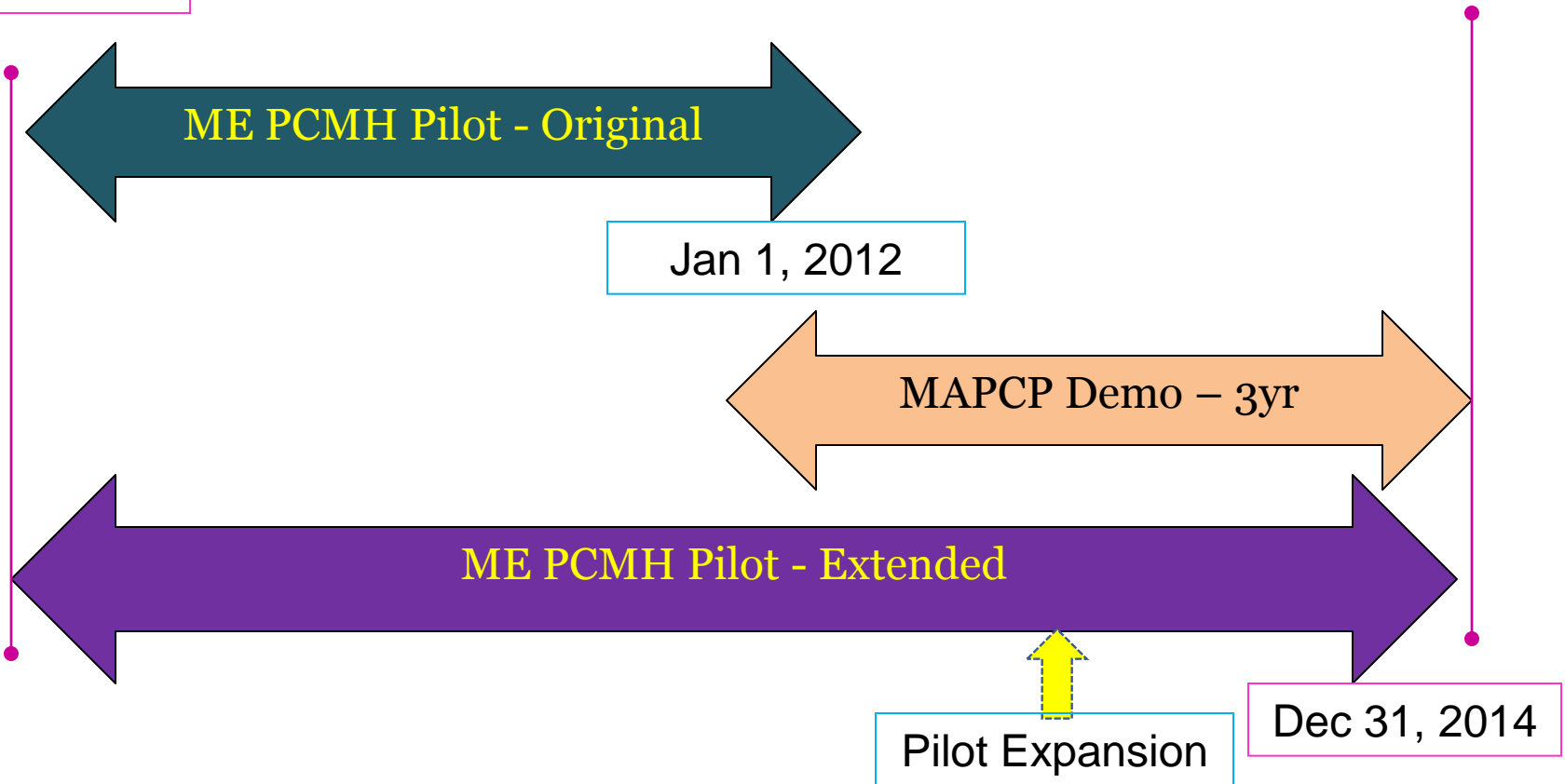
Jan 1, 2012

MAPCP Demo – 3yr

ME PCMH Pilot - Extended

Pilot Expansion

Dec 31, 2014

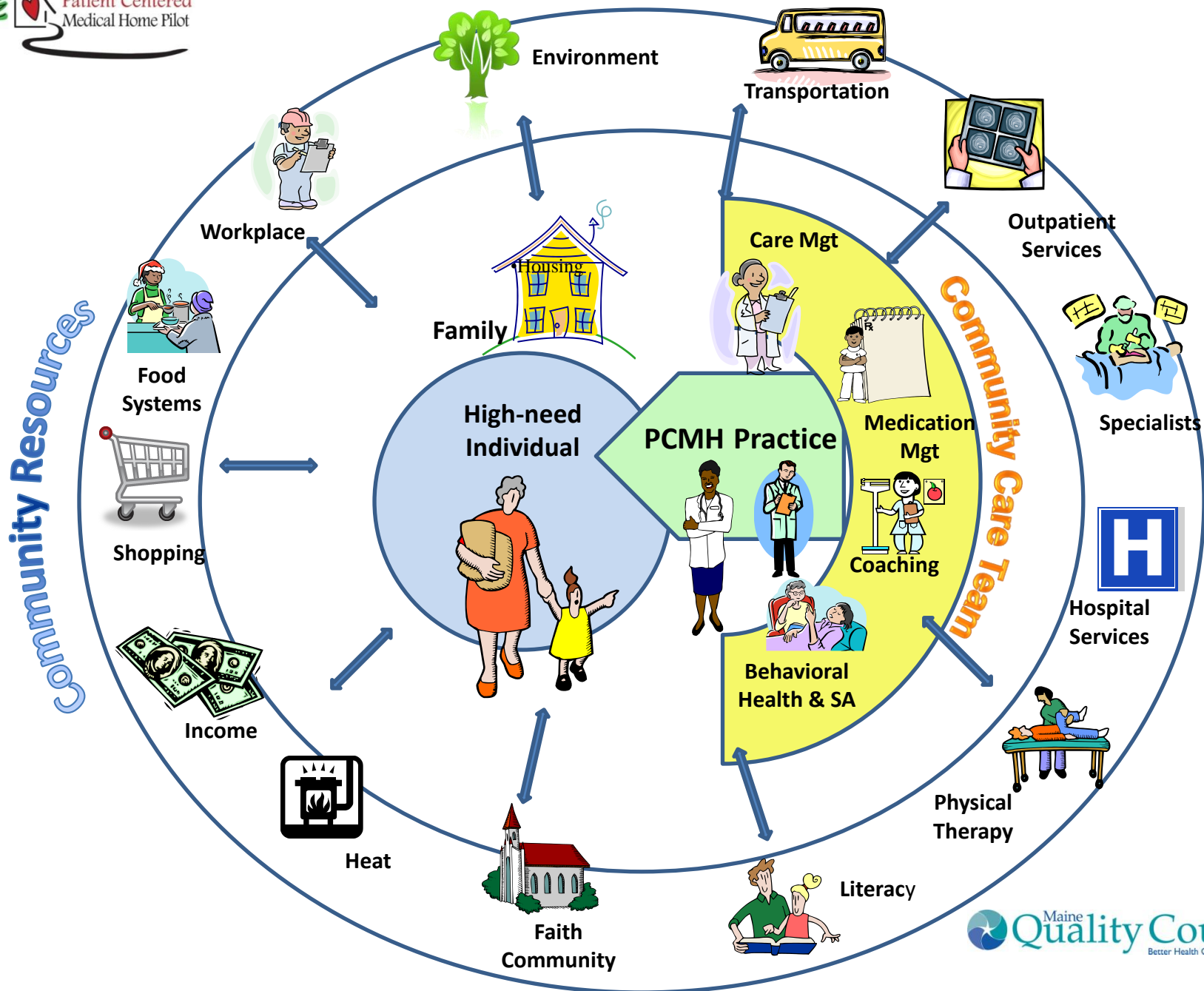




Community Care Teams

- Multi-disciplinary, community-based, practice-integrated care teams
- Build on successful models (NC, VT, NJ)
- Support patients & practices in Pilot sites, helping patients overcome barriers to care, improve outcomes
- Receive pmpm payments from Medicaid, Medicare, commercial payers
- Key element of cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (ED use, admits)

Maine PCMH Pilot Community Care Teams





ME PCMH Pilot CCTs

- Androscoggin Home Health
- Coastal Care Team (Blue Hill FP, Community Health Center/MDI, Seaport FP)
- Community Health Partners (Newport FP, Dexter FP)
- DFD Russell
- Eastern Maine Homecare
- Kennebec Valley (MEGenl)
- MMC
- PCHC



Pilot Phase 2 Expansion

- 20 new adult practices to be selected for participation in multi-payer Pilot
- Will enter Pilot (with payment) Jan 2013
- Expectations:
 - Strong leadership for change
 - NCQA PCMH recognition (Level 1 or higher)
 - Fully implemented EMR
 - Commitment to implement Pilot Core Expectations

CMS Health Homes – ACA Section 2703



- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid “State Plan Amendment”
- Health Homes may serve individuals with:
 - » Two or more chronic conditions
 - » One chronic condition and who are at risk for another
 - » Serious mental illness
 - Adults with serious & persistent mental illness (SPMI)
 - Children with severe emotional disturbance (SED)
- Dual eligible beneficiaries cannot be excluded from Health Home services

Chronic conditions include:

- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Overweight (BMI > 25) & Obesity
- Other – to be proposed by state (and approved by CMS)

Required Health Home services include:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support
- Referral to community and social support services
- Use of health information technology (HIT)
- Prevention and treatment of mental illness and substance abuse disorders
- Coordination of and access to preventive services, chronic disease management, and long-term care supports

CMS Health Homes – Required Measures

- Core Set – Quality Measures
 - Adult BMI assessment
 - Ambulatory Sensitive Condition admission rate
 - Care transitions record transmitted to PCP (within 24hrs)
 - Follow up after mental health admission
 - All-cause 30 day readmission rate
 - Depression screening & follow up
 - Initiation & engagement of treatment for alcohol/drug dependence
- State-Specific Goals & Measures
 - State must set HH measurable goals (e.g reduce ED visits)
 - Must identify measures to operationalize those goals

Maine Health Homes Proposal

Stage A:

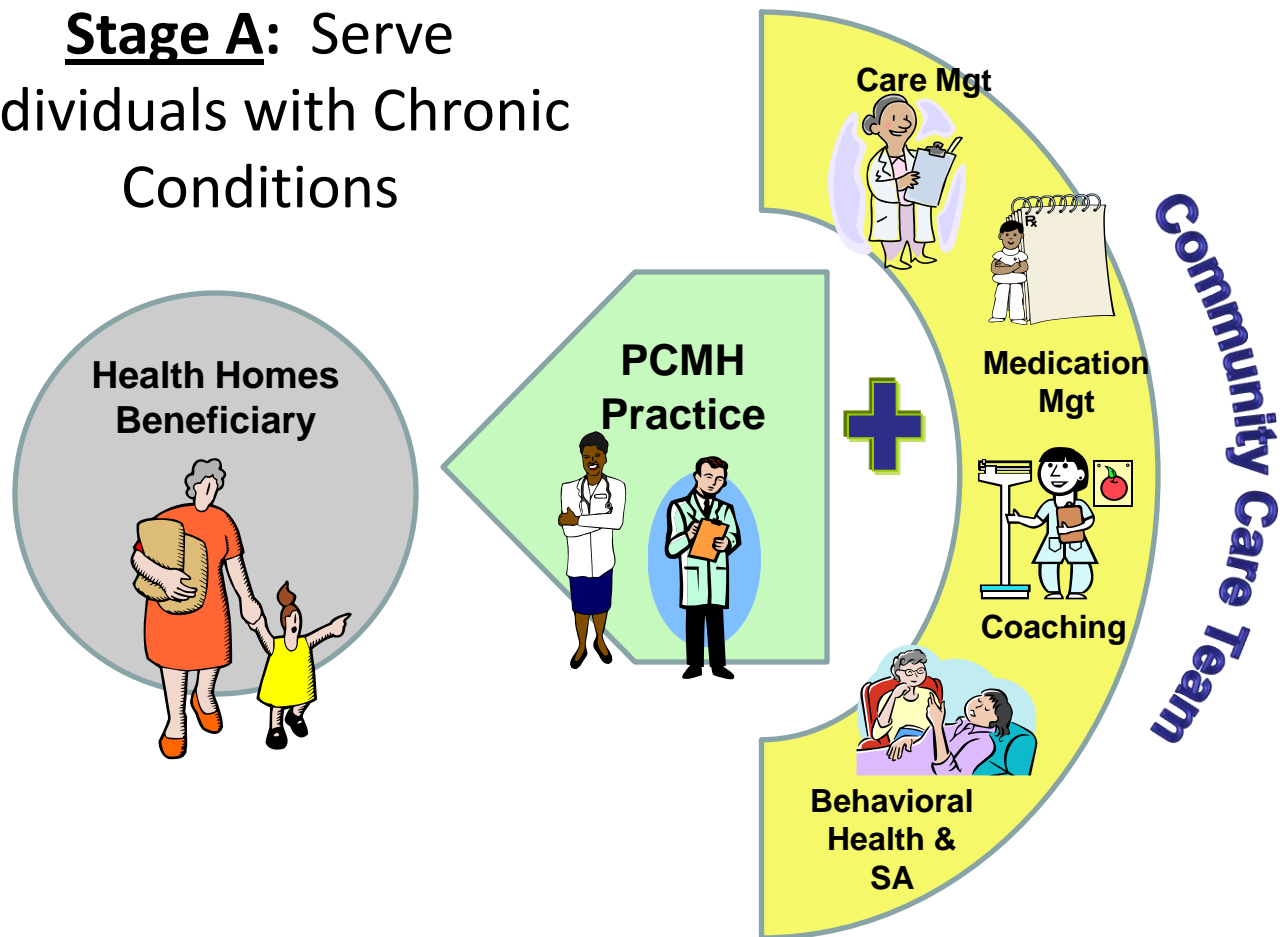
- Health Home = Medical Home primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
 - » Two or more chronic conditions
 - » One chronic condition and at risk for another

Stage B:

- Health Homes = Community Mental Health Center (CMHC) CCT + Medical Home primary care practice
- Payment weighted toward CMHC CCT
- Eligible Members:
 - » Adults with Serious and Persistent Mental Illness
 - » Children with Serious Emotional Disturbance

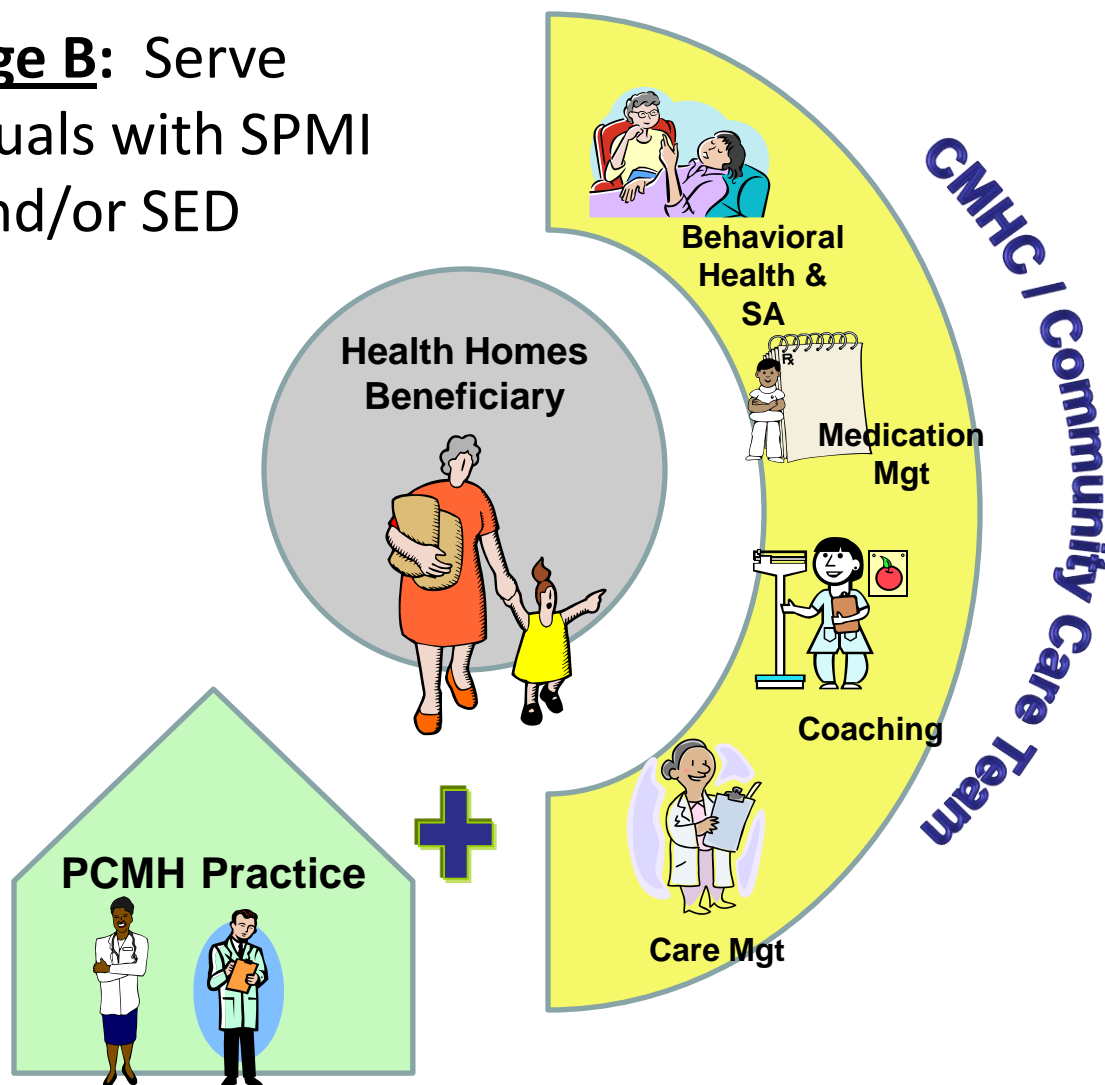
Maine Health Homes Proposal

Stage A: Serve
Individuals with Chronic
Conditions



Maine Health Homes Proposal

Stage B: Serve
Individuals with SPMI
and/or SED



Process:

- Interested practices apply through joint PCMH Pilot/ Health Homes online application
 - http://www.surveymonkey.com/s/ME_PCMH_Pilot_Phase2_Expansion_Applic
 - Due by March 31, 2012
- 20 practices will be selected for multi-payer PCMH Pilot Phase 2 expansion
- All other practices meeting basic qualifications will be eligible to become MaineCare Health Home
- CCTs will be selected through separate application process (May-June 2012)

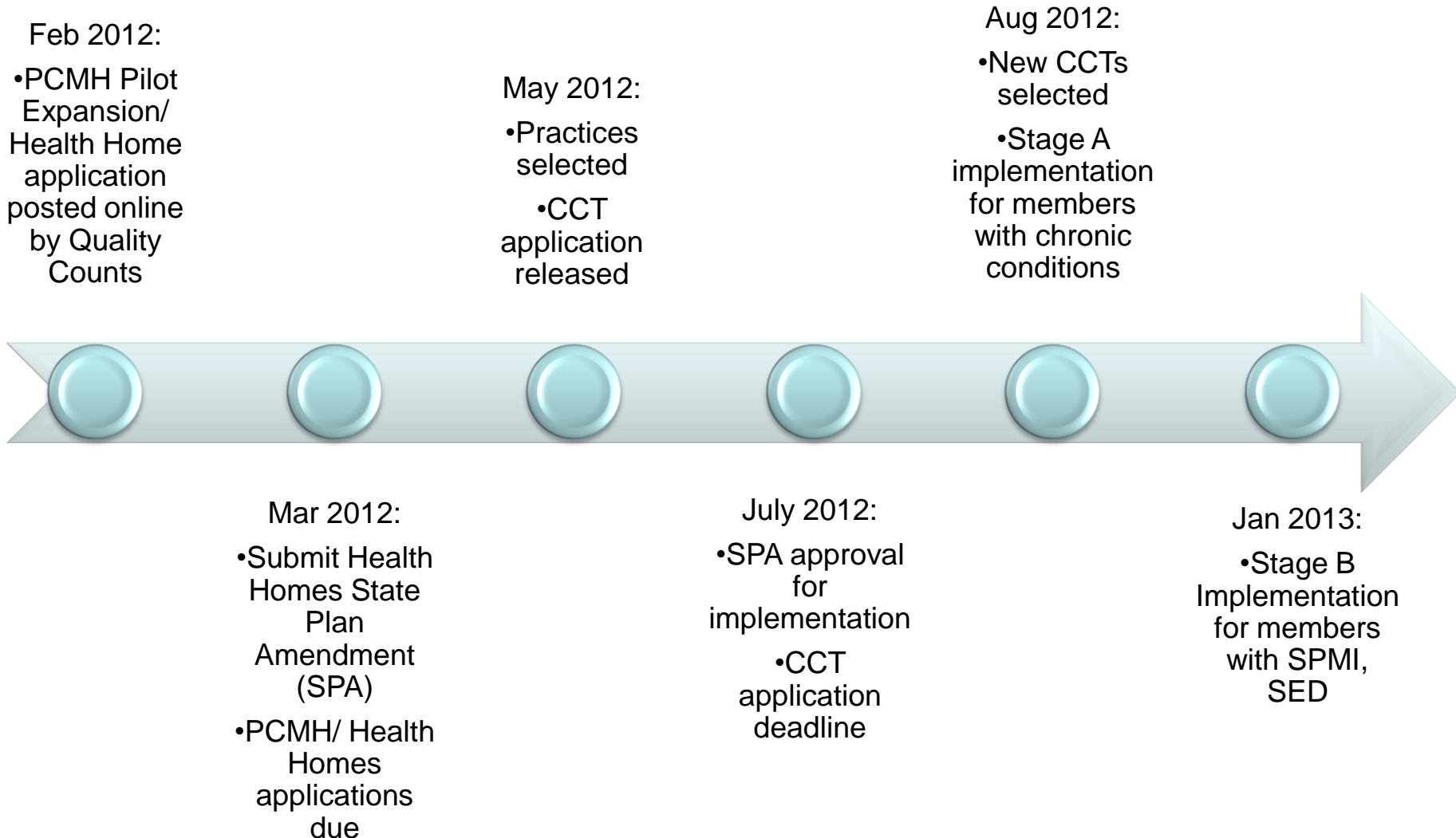
Eligibility – MaineCare Health Homes:

- Pediatric or Adult Primary care practice site with at least one full-time primary care physician or nurse practitioner
- NCQA PCMH recognition (Level 1 or higher)- submitted application by time of selection (May 31, 2012)
- Fully implemented EMR
- Commitment to meet Maine PCMH 10 Core Expectations
- Commitment to provide CMS-mandated Health Homes services
- Agreement to identify Maine PCMH Pilot Community Care Team (CCT) to partner in managing high-needs patients

Eligibility – Maine PCMH Pilot Expansion:

- Practice meets MaineCare Health Home requirements
- Adult primary care practice site with at least one full-time primary care physician or nurse practitioner
- Practice site does **not** currently participate in the CMS FQHC Advanced Primary Care (APC) Demonstration
- Minimum patient panel of 1000+ patients enrolled in Pilot health plans (Anthem BCBS, Aetna, Harvard Pilgrim Health Care, MaineCare, and Medicare).
- Completion of Maine PCMH Pilot Phase 2 Expansion “Memorandum of Agreement” (MOA)

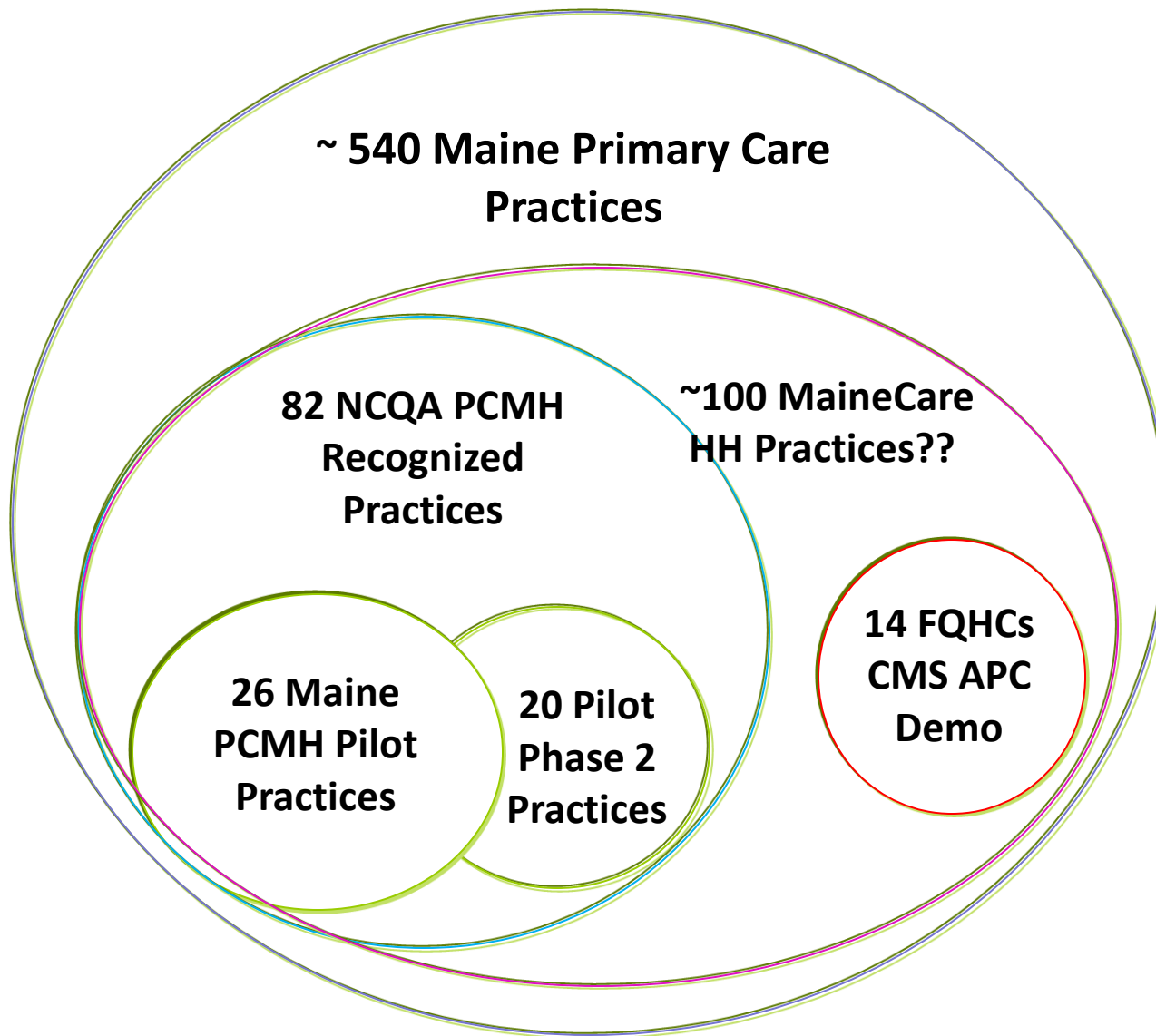
Health Homes Timeline



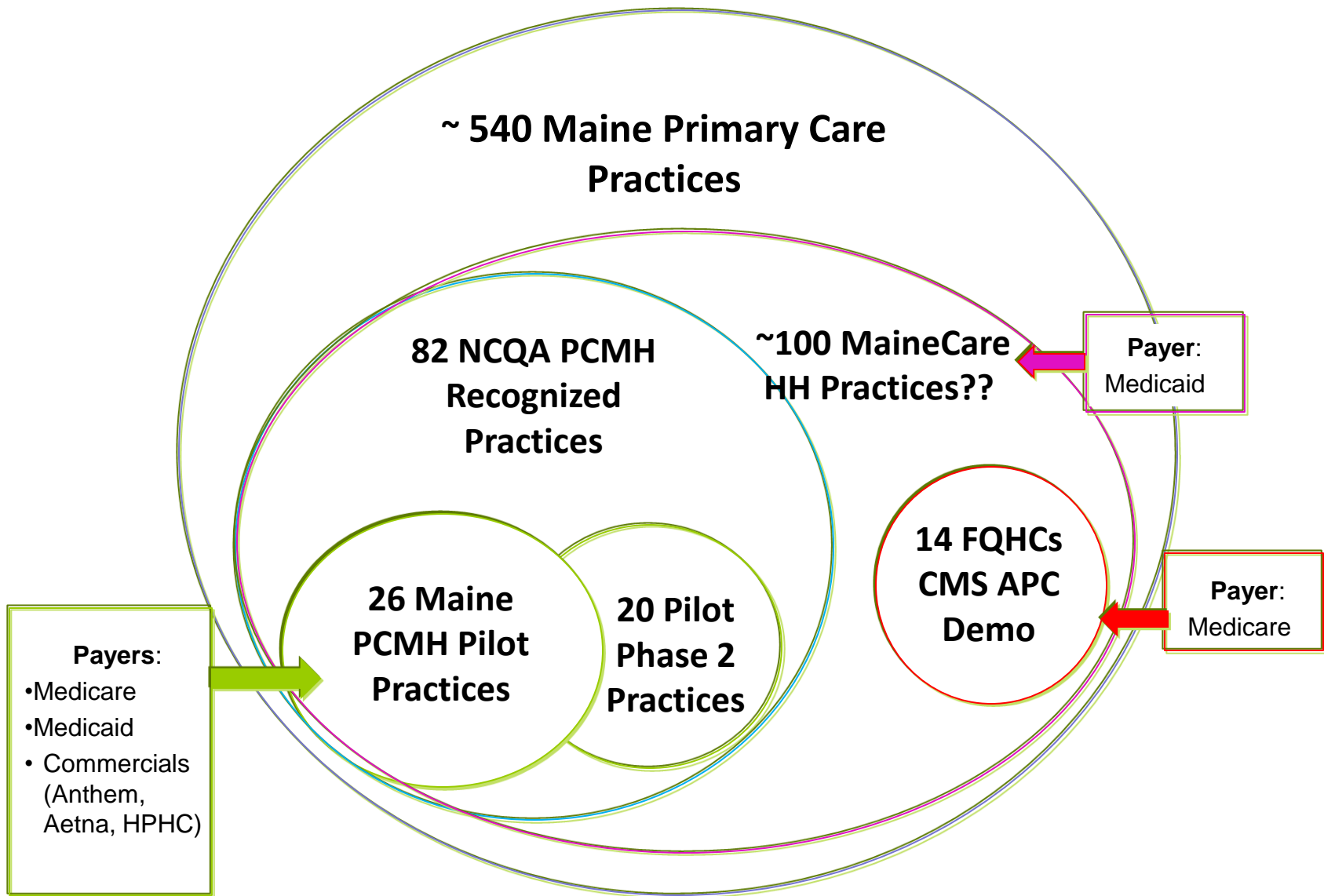
PCMH Pilot & Health Homes Timeline

- Feb 1, 2012 – Joint Phase 2 & HH practice applic posted
- **Mar 31 - Deadline for online practice applications**
- April-May – Applications reviewed
- May 1 – Phase 2 CCT application posted
- May 31 - Pilot Phase 2 & HH practices selected
- July 1 – MaineCare HH program begins (*targeted*)
- July 15 – Deadline for CCT online applications
- August 1 – Phase 2 CCTs selected
- January 1, 2013 – Pilot Phase 2 practices and CCTs enter Maine PCMH Pilot

Other Medical Homes in Maine



Other Medical Homes in Maine



Programs

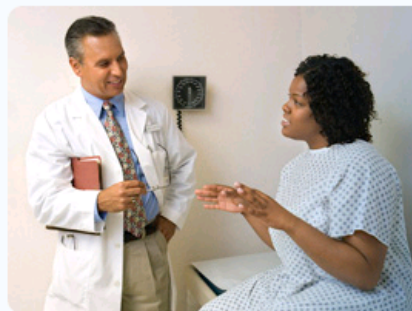
Patient Centered Medical Home
Aligning Forces for Quality
QC Learning Community
Behavioral Health Integration
Pressure Ulcer Prevention
Electronic Health Records to Improve Care
Patient Family Leadership Team
IHOC - Quality Counts for Kids
Community Health Teams
Transforming Care at the Bedside
AF4Q Equity - ME Race, Ethnicity and Language Initiative

PCMH Links

PCMH Home
Assessing Practice Readiness
Support for Practice Transformation
Tools and Resources

Home ▶ Programs ▶ Patient Centered Medical Home

Patient Centered Medical Home



Recognizing the essential role of primary care in our healthcare system, the Maine Quality Forum (MQF), *Quality Counts*, and the Maine Health Management Coalition are working together to lead the Maine Patient Centered Medical Home (PCMH) Pilot. Following an initial planning period, the group selected a group of 26 primary care practices in May 2009 to implement the PCMH model as a first step in ultimately achieving the goal of statewide implementation of a patient centered medical home model.

PCMH Learning Session 6: The Medical Home Run

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Learning Session 6 for the Patient Centered Medical Home Pilot was held on Friday, June 3rd. The program focused on reducing avoidable health care costs. The day-long Session provided opportunities for the Pilot practice teams to learn more about steps they can take, in collaboration with their "medical neighbors", to address the important task of working together to reduce avoidable health care costs. One of the speakers, Arnold Milstein, based his talk on his 2008 blog entitled *Medical Homes—And Medical 'Home Runs'*. This posting can be found at: <http://healthaffairs.org/blog/2008/09/10/medical-homes-and-medical-home-runs>. Some of the presentation slides and handouts from this session are now available.

[Read more...](#) [Add new comment](#)

PCMH Learning Session 5 a Success!

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The Maine Patient Centered Medical Home Pilot's

Payment Model & Financial Case for PCMH

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The Case for Enhanced Payment for



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Current Projects

[Health Information Technology \(HIT\)](#)

[HIPAA 5010](#)

[NEW! Improving Health Outcomes for Children \(IHOC\)](#)

[Value Based Purchasing](#)

[PNMI Initiative](#)

[Transportation Initiative](#)

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Value-Based Purchasing (VBP) Strategy

All documents and materials on the MaineCare web pages reflect MaineCare's current thinking and are subject to change. No materials on the web page, distributed and discussed at meetings, or sent in emails or mailings are binding in any way concerning the future procurement process.

- [Design Management Committee](#)
- [Member Standing Committee](#)
- Quality Counts presentation 11/22/2011 ([.pdf](#) | [.ppt](#))
- [Request For Information \(RFI\)](#)
- [Resources page](#)
- [Specialized Services/ Stakeholder Advisory Committee](#)
- [Tribal Consultation](#)
- Value-Based Purchasing Strategy Announcement: Commissioner memo ([.pdf](#)) Fact Sheet ([.pdf](#))

Design Management Committee

- Presentation January 9, 2012 ([.pdf](#) | [.ppt](#))

Member Standing Committee

Future Meetings

February 3, 2012

- Agenda ([.doc](#))

Past Meetings

November 18, 2011

- Agenda ([.doc](#))
- Presentation ([.ppt](#))
- Meeting Notes ([.doc](#))

Contact Info / Questions

- Maine PCMH Pilot: www.mainequalitycounts.org
(See “Major Programs” → “PCMH Pilot”)
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- MaineCare Health Homes
 - Michelle Probert: michelle.probert@maine.gov